STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from December 1, 2011 through December 12, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 110. The Stage II sample totaled thirty-nine (39) residents.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen M. Deuce	Administrator (CNHA)	12/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to immediately report an allegation of neglect for R167 and an allegation of misappropriation of property for two residents (R167 and R3) out of 39 sampled residents to the State agency. Findings include: The facility procedure entitled "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Origin, and Misappropriation of Resident Property", Section "Policy", stated that "all allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies ....." . Section 1.1.9, Section A", under "Prevention and Reporting", stated that "Report all alleged violations ... to the state agency ....and take all necessary corrective actions". 1. Review of a facility incident report, dated 8/15/11, revealed that on 8/13/11, the funeral home and R167's family alleged that one ring (of three rings R167 had) was missing when the resident's body was sent to the funeral home. The inventory of personal effects for R167	F 225	F225 January 30, 2012 1. Resident R167 no longer resides in the center. Resident R3 has no concerns at this time and an investigation showed no evidence of neglect.. 2. Incidents/accidents and complaints are reviewed daily during morning managers meeting to determine that investigations were initiated, completed, and reported in accordance to State and Federal laws. 3. The leadership team will be informed by the administrator on or before January 1, 2012 on their responsibility and the process of reporting and investigating alleged abuse, neglect, mistreatment, and/or injuries of unknown sources. Random incident audits of 5% will be conducted by the DON/NHA over the next 30 days to review documentation to determine that proper and timely procedures are followed. 4. The NHA will report to the QA committee monthly. The QA committee will analyze the data to determine the need for further recommendations and follow-up to enhance and improve outcomes.	

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F 225	Continued From page 2 indicated she had three rings when R167 was admitted to the facility. The facility investigated and was unable to locate the missing ring. The incident and supporting documentation for the incident were done on 8/13/11. However, it was not reported to the state until 8/15/11. During an interview on 12/12/11, E1 (Administrator) acknowledged the findings. The facility failed to immediately report the missing ring to the state agency and reported the initial and five day follow up of R167's missing ring on 8/15/11. 2. Review of a facility Resident Concern Report, dated 9/19/11, revealed that on 9/18/11, R3 alleged that the staff failed to provide morning care on 9/18/11. The facility investigated the concern. However, the facility failed to report the allegation of neglect to the state agency. During an interview on 12/12/11, E1 (Administrator) acknowledged the findings. She stated that she thought that the incident was not reportable.	F 225		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced	F 246		

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F 246	Continued From page 3 by: Based on observation and interview, it was determined that two (R35 and R15) out of 37 sampled residents did not have a call bell placed within reach to call for assistance. Findings include: 1. On 12/6/11 at 2:30 PM, R35 was noted to have her call bell clipped to the right side of her side rail and was hanging from the rail. The resident was asked to reach and ring the call bell. The resident was unable to reach the call bell because it was clipped out of her reach. The call bell was relocated for the resident so she could use it by the aide (E13). In an interview with E9 (Nurse) on 12/6/11, she confirmed the call bell should be within reach. The resident's care plan included risk for falls, and resident required two person assist to get out of bed. 2. Observation of resident R15 on 12/8/11 at 2:30 PM with E1 and E14 (Environmental Service Director) revealed that the call bed was lying on the middle of the bed and the resident was sitting by the bedroom wall. The call bell was inaccessible to R15. The call bell was relocated for the resident by the nurse (E9) so she could use it. In an interview with E9 on 12/8/11, she confirmed the call bell should be within reach.	F 246	F246 January 30, 2012 1. Resident R35 and R15's call bell has been relocated so she can reach and use it. 2. Random rounds have been accomplished to identify any other residents identified as having issues with call bells not in reach. 3. Nursing staff has been informed of the importance of having call bells located where residents can use them. Random unit rounds will be performed weekly over the next 30 days to determine compliance. 4. This will be the responsibility of the DON/ADON/Unit Managers. The DON will report monthly to the QA committee. The Committee will determine the need for further recommendations.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations during stage I of the QIS process, and the environmental tour of the facility with the environmental service director (E14) and the administrator (E1) on 12/8/11, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly and sanitary interior. Findings include: 1. The protective plate in resident rooms, or bathrooms, door knobs for rooms: 404, 512, 600, 608 were observed in disrepair. 2. Stained ceilings, or ceilings in disrepair, were observed in resident rooms: 205, 307 and 407. In an interview with E14 (Environmental Service Director) on 12/8/11, he stated that the roof for the facility had been replaced. E14 stated he was waiting for the roof work to be acceptable before correcting the ceiling concerns inside the facility. E14 stated the outside roof was repaired approximately two months ago. 3. The caulking around the base of the toilet in the 200 unit common shower room bathroom was observed stained and in disrepair. 4. Stained bathroom carpet was observed on the floor of resident room 101 and 106. 5. A filter was missing from resident room 407B oxygen concentrator unit on 12/8/11 at 2:25 PM. The oxygen concentrator was not in use at the time. 6. R101's bed side rail was in disrepair on 12/2/11	F 253	F253 January 30, 2012 1. Building maintenance issues identified during the survey have been corrected. Carpet does not exist in rooms 101 and/or 106, however, the tile floor is clean and aged. The center may consider replacing the floor. 2. Current residents have not indicated any issues with sanitary, orderly, or comfortable interior of the building. Staff have been informed to report disrepairs to maintenance. 3. Random environmental audits will be performed by Maintenance Director /NHA over the next 30 days to validate an orderly and sanitary interior environment. 4. This will be the responsibility of the maintenance team who will report findings to the administrator.	

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F 253	Continued From page 5 and posed a fall risk. 7. A gap (equal or greater than 4 inches) between the mattress and the footboard of the bed was observed in the resident rooms 300A (R116) and 303B (R39). In an interview with E14 on 12/8/11 for room 303B, he stated that the bed mattress was not sized properly for the size of the bed. In the two residents ' rooms, the lock, or latch at the foot board area of the bed, was observed in improper positioning, making the mattress move on the bed. E14 corrected the latch and stated they have a project to replace all mattresses in the unit shortly. On 12/8/11, an interview with E14 confirmed these findings.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		

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F 278	Continued From page 6 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the MDS (Minimum Data Set) assessment for two (2) residents (R180 and R208) out of 39 stage 2 sampled residents, failed to accurately reflect the resident's status. Findings include: 1. Review of R180's Nursing Comprehensive Admission Data Collection and Assessment, dated 11/2/11, revealed that R180 had "broken" natural teeth. R180's Admission MDS (Minimum Data Set), dated 11/9/11, failed to code for "...broken natural teeth". During an interview on 12/12/11 at 7:29 AM, E3 (Assistant Director of Nursing/ADON) acknowledged the finding. The facility failed to accurately reflect R180's oral assessment on her admission MDS, dated 11/9/11. 2. Review of R208's Nursing Oral Assessment, dated 11/17/11 revealed that R208 had natural	F 278	F278 January 30, 2012 1. Residents R180 & R208 no longer reside at the center. 2. Current residents who are assessed by nursing to have dental concerns, will be reviewed by the ICP team at their next scheduled care plan meeting to ensure accuracy of the MDS and that care plans are developed as appropriate. 3. The MDS coordinators (CRC's) have been informed of the survey findings and will perform random MDS audits over the next 30 days for new admissions to ensure MDS coding accuracy. 4. This will be the responsibility of the Clinical Reimbursement Specialist (CRS) and the CRC'S. The CRS/designee will report to the QA committee monthly. The QA committee will analyze the data for further recommendations.	

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F 278	Continued From page 7 teeth missing, loose. No artificial teeth. R208's Admission MDS (Minimum Data Set) Assessment, dated 11/17/11, failed to code for "...teeth missing/loose teeth". During an interview on 12/8/11, E4 (RNAC) confirmed these findings. The facility failed to accurately reflect R208's oral assessment on her admission MDS Assessment, dated 11/17/11.	F 278	F323 January 30, 2012 Cross Refer to F323 Survey Ending November 14, 2011 1. Resident R101's side rail is functioning properly. Supply Closets are secured. 2. An audit will be completed before December 16th to ensure that rails are functional and locked as appropriate. The nursing staff have been informed to report any issues with non-working side rails to the maintenance staff and to keep supply closets closed. 3. The center has received all new beds and new side rails. Random audits will be performed by the maintenance staff to ensure rails are in working order and used properly. 4. This will be the responsibility of the maintenance staff who will report to the safety committee monthly.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and review of other facility documents, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazards as is possible when one side rail was observed unsecured, unlocked and a potential hazard for one (R101) out of thirty-nine (39) sampled residents. Additionally, the facility failed to maintain the environment free from accident hazards as evidenced by accessible chemicals and disposable razors in unlocked supply closets on the North and South Wings. Findings include:	F 323		

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F 323	Continued From page 8 The facility's policy and procedure, dated 01/09 and entitled, "Fall/Injury Assessment: Prevention and Management Plan of Care" was reviewed. 1. R101 was admitted to the facility on 5/19/11. R101's diagnoses included Parkinson's disease, a history of stroke, dementia; hypertension, arthritis, anxiety disorder and depression. Review of R101's Quarterly MDS (Minimum Data Set) Assessment, dated 11/8/11, revealed that R101 was coded as "3,3" (extensive assistance requiring two + persons physical assist) for bed mobility and coded, "4,3" (Total dependence requiring two + persons physical assist) for transfer. R101's care plan, dated 5/19/11 (last reviewed on 11/8/11) and entitled, "...ADL/Mobility deficit r/t (related to) CVA (stroke) as evidenced by general weakness and easily fatigued listed interventions that included, "...Provide assistive device as needed for bed mobility: 2 half rails." Another care plan, dated 5/19/11 (last reviewed on 11/8/11) and entitled, "Fall/Injury Risk related to: total care, exhaustion, weakness, cardiovascular diagnosis, bowel incontinence, bladder incontinence, dementia, Alzheimer's and CVA " listed interventions included. "enablers... 2 1/2 rails..." On 12/2/11 at 09:39 AM, R101's right side rail was observed broken, not locking, and leaning against the wall behind the head board. The wall was noted to have multiple scratches/marks which appeared to have been made by this side rail. R101 was not in the room at this time.	F 323		

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F 323	Continued From page 9 During an interview on 12/2/11, E11 (nurse) checked R101's side rail at the surveyor's request and stated that it "does not click" and could not lock. She immediately notified maintenance of the broken side rail. E11 did not know how long the side rail had been broken. During an interview on 12/9/11 at 9:21 AM, E12 (Environmental Services Assistant) stated that he had replaced the bracket on R101's side rail. He stated that it was bent and prevented the side rail from locking. He stated that he repaired it the same day when E11 had notified him of the broken side rail. E12 stated that he relies on staff to notify him of problems and at times does random checks of side rails when he is in a resident room but denied having any regular system to check side rail function. During an interview on 12/12/11, E1 (Administrator) acknowledged the findings. The facility failed to maintain a safe environment as per the plan of care for R101 on 12/2/11 when the resident's right half side rail was observed unsecured, unlocked and leaning on the wall. This posed a potential accident hazard for R101 who was on fall precautions. 2.Observations on 12/1/11 during the initial tour, and 12/6/11 and 12/7/11 revealed that the doors of the supply closets on the North and South Wings were propped open with rubber door stops and empty boxes. These supply closets contained eight, 12 ounce bottles of Personal Cleaner on the shelf that was marked "For external use only. In case of accidental ingestion get medical help or contact Poison Control Center immediately". In addition, there was one box of 50	F 323		

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F 323	Continued From page 10 count disposable single blade razors. All of these items were assessable to residents. Interviews on 12/7/11with E2 (Director of Nursing), E8 (Medical Records Clerk-Supply Distributor) and E9 (Unit Manager) confirmed that these doors are to remain closed at all times for resident safety.	F 323	F371 January 30, 2012 1. The mixing valve was replaced to ensure proper water temperatures with the staff bathroom sink and handwashing sink. The three compartment sink continues to show appropriate sanitizing solution. 2. The three-compartment sink is filled and checked for proper sanitation at each fill by the cook supervisor. 3. The Dietary director will perform random audits of the sanitizing solution over the next 30 days to ensure proper sanitation. 4. This will be the responsibility of the dietary director who will inform the NHA of any discrepancies that need correcting by the chemical vendor or the identification of other issues.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to prepare, serve and distribute food under sanitary conditions. Findings include: 1. Observations on 12/1/11 at 8:30 AM of the kitchen dietary staff hand sink revealed the hot water to be below the temperature of 100 degrees Fahrenheit required by the Delaware 2011 Food Codes. The temperature was recorded at 58.9 degrees Fahrenheit after allowing the water to run for at least three minutes. Additionally, the water temperature of	F 371		

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F 371	Continued From page 11 the hand sink located in the kitchen staff bathroom was detected to be at a temperature of 78.7 degrees Fahrenheit. In an interview with E15 (Cook) on 12/1/11, she confirmed this finding and would not elaborate further. In an interview with E16 (Food Service Director) on 12/1/11, he stated the surveyor needed to talk to the maintenance director about the water temperatures. 2. Observations of the three compartment sink made during the tour of the kitchen on 12/1/11 at 8:40 AM with E15 (Cook and Person-in-Charge) revealed cleaned trays on the sanitizing solution of the sink at the time. The sanitizer solution concentration was tested using a test strip by E15 leaving the test strip for 10 seconds inside the solution. She detected no sanitizer, or traces of the sanitizer, when she used the standard testing protocol of 10 seconds. The procedure called for the sanitizer solution to be between 150 PPM to 400 PPM. E15 made another solution of the sanitizer, and again traces or no sanitizer was detected. E15 stated she would let the Food Service Director know about this concern. An interview with E16 (Food Service Director, FSD) on 12/1/11 at 11:30 AM revealed he had contacted the sanitizing vendor to check the sanitizing solution in the three-compartment sink. On 12/5/11, E16 (FSD) stated he contacted the vendor and the vendor had raised the level of the sanitizer concentration to 200-250 PPM levels. Copies of the vendor information was requested and not provided at that time. On 12/9/11 at 2:15 PM, a test of the 3-compartment sink sanitizing solution was done by E16 revealing traces of the sanitizer, or no	F 371		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 sanitizer, in the solution of the 3-compartment sink. E16 stated he was unaware how long the solution had been sitting in the 3-compartment sink. A second solution was made up by E16 and tested. The sanitizer concentration was measured at 150 PPM. The food service director then tested the concentration of made up solution and tested it with a new test strip which showed the concentration higher. On 12/9/11, findings were reviewed with the administrator (E1) and E16. E1 disagreed that they had a problem with the sanitizer but with the test strip to test the sanitizer. In an interview with the sanitizer vendor on 12/9/11 at 3:55 PM, the vendor stated he made an adjustment to the sanitizer dispensing tip so that the facility would get a higher concentration of the sanitizer. The sanitizing solution when he tested it on 12/1/11 was marginal. He stated that the test strip may have been a problem in measuring correct sanitizer solution in the three compartment sink and he will verify that with another visit to the facility.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the drugs and biologicals that were stored in the medication rooms including the refrigerators were not expired. Findings include: Observation on 12/7/11 of the North Wing medication room revealed: One (1) 30ml (milliliter) bottle of Heparin Lock Flush Solution (sodium chloride) that had expired on 8/2007. Twenty Four (24) Filter needles	F 431	F431 January 30, 2012 1. The expired medications and needles were removed from the medication room. 2. The unit managers on each North and South side performed an audit to ensure no other items were expired in the medication room or the refrigerator. 3. The pharmacist consultant has been informed of the survey findings and will perform monthly audits of the medication room to assist the center in discarding expired items. 4. The pharmacist consultant will submit a monthly report to the DON who will report monthly to the QA committee. The Committee will determine the need for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 14 19guagex1-1/2inch, eight expired 7/11, eight expired 9/11 and eight expired 10/11. Twenty Four (24) 12.5mg (milligram) Promethegan Rectal Suppositories for R78 that had expired on 9/11. Ten (10) 25mg Promethazine Rectal Suppositories for R40 that had expired on 11/11. During an interview with E9 (Unit Manager) on 12/7/11 immediately after the observation, E9 confirmed these findings and removed and disposed of these medications and supplies. Observation on 12/7/11 of the South Wing medication room revealed: One (1) unopened 250 count tablet bottle of Folic Acid 400mcg (microgram) which had expired on 7/11. In an interview with E10 (RN) on 12/7/11 immediately after the observation, E10 confirmed this finding and removed and disposed of this medication.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 15 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to handle linen to reduce the potential for the spread of disease as evidenced by the storage of soiled linen on two of the facility's (North Wing) hallway not stored under negative pressure. Findings include: 1. Observations of the facility's 100 unit hallway on 12/6/11 at 10:50 AM revealed a three compartment cart (trash in one compartment and	F 441	Cross Refer F441 Survey ending 12/14/11 F441 January 30, 2012 1. The certified nursing assistant has been informed and is currently being randomly monitored for compliance of soiled linen handling. 2. No other observations were identified for failure to follow an infection control program. Random rounds will be performed over the next 30 days to observe safe linen handling. 3. An in-service will be performed on or before January 15, 2012 to review Infection Control practices and policies on safe linen handling and transport of linen for the certified nursing assistants. 4. This will be the responsibility of the Infection Control Nurse who will report to the DON monthly. The DON will report monthly to the QA committee. The Committee will determine the need for further recommendations.	

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	085039	A. BUILDING _____ B. WING _____	12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 16 overflowing soiled linens in the other two compartments) were stored in the hallway outside resident room 105, and was not under negative pressure. An offensive odor was detected in the area. On 12/6/11, E9 (Nurse) and E17 (Housekeeping/Laundry Supervisor) confirmed this finding. 2. Observation of the facility's 200 unit hallway on 12/5/11 at 1:30 PM revealed a two-compartment cart (one bin full of trash and another bin full of soiled linen) were stored in the hallway across from room 207 and was not under negative pressure. An offensive odor was detected in the area. In an interview with E18 (Nursing Aide) on 12/5/11, she confirmed the finding. 3. Observation of the facility 200 unit hallway on 12/8/11 at 2:00 PM made during the environmental tour of the facility with E1 (Administrator) and E14 (Environmental Service Director) revealed a two-compartment cart (trash in one bin and soiled linen in another bin of the cart) was stored in the hallway outside resident room 204 and was not under negative pressure.	F 441	F463 January 30, 2012 1. Call bells in room 310 and 407 are in working order and are audible at the nurses station. 2. A random check of the nurse call system has been performed by maintenance staff and no other issues have been identified. 3. The center maintenance director/designee will perform monthly random audits to ensure call system is in working order. The C.N.A.'s have been informed to report any call bell issues to the maintenance department. 4. This will be the responsibility of the maintenance staff who will report findings to the NHA for further recommendations to improve outcomes.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made during the environmental tour of the facility, and staff	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 463	Continued From page 17 interviews, it was determined that the facility failed to ensure that the resident call system was functional for two resident rooms (310A and 407A) out of 47 rooms inspected. Findings include: 1. Observation of resident room 310A's bedroom call light on 12/8/11 at 2:20 PM made during the environmental tour of the facility with E1 (Administrator) and E14 (Environmental Service Director) revealed that the call light was not functioning (no audio or visual). The non-functional bedroom call light was verified by E14. On 12/12/11 at 9:03 AM, the emergency call light system was still not working. 2. Observation of room 407A emergency call light on 12/8/11 at 2:35 PM, pulled for testing during the environmental tour with E14, revealed that an audible alarm was heard at the hallway and the light outside the room were functioning properly, yet the aide did not respond to the call bell for about six to seven minutes later. Further observation of the call light system for room 407A on 12/8/11 (to determine why it took a staff that long to respond to the alarm) revealed that although the call light system was functioning properly by the resident room, the nursing station annunciator (which indicated which room the emergency call was coming from) only showed the light but was missing the audible sound and therefore staff (Nursing and Social Services) that were sitting at the nursing station did not respond to the call.	F 463		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside	F 467		

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	085039	A. BUILDING _____ B. WING _____	12/12/2011

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F 467	Continued From page 18 ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain adequate ventilation as reflected by malfunctioning exhaust vents in the facility's 200 unit (North wing) common shower room and resident bathrooms. Findings include: Observations made during the environmental tour of the facility on 12/8/11 at 2:00 PM with E1 (Administrator) and E14 (Environmental Service Director) revealed an odor in the shower room (room 203) of the North wing of the facility as you entered the shower room. The exhaust vent in the shower room was not drawing air into the vent or working. E14 on 12/8/11 then proceeded to test resident room 200 bathroom exhaust vent, which was in the same hallway, and E14 found the vent was also not working. E14 stated that the exhaust vents in the shower room and all rooms of the 200 hallway unit of the facility were connected to the same ventilator system on the roof and therefore none of the residents' bathroom vents in the unit were working. E14 was observed calling another maintenance staff to check on the exhaust vent for the 200 unit. On 12/12/11, E1 confirmed the motor for the exhaust system for the 200 shower and resident's room vents was replaced the same day.	F 467	F467 January 30, 2012 1. The exhaust fan has been replaced that operates in the shower room and the 200 wing 2. A random check of the ventilation system was performed and no other discrepancies were found. 3. The center maintenance director/designee will perform monthly preventative maintenance checks of the ventilation system. 4. This will be the responsibility of the maintenance staff who will report findings to the NHA for further recommendations to improve outcomes.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 085039	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT NEW CASTLE	**32 BUENA VISTA DRIVE NEW CASTLE, DE**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, it was determined that the facility failed to ensure that grievances expressed by residents or their families were addressed. Findings include:

An interview with R101's daughter on 12/5/11 revealed that R101 was missing a CD (Compact Disc) and Hymn book since last week. The CD was found in another resident's room, but the hymn book was never found.

An interview with E5 CNA (Certified Nursing Assistant) on 12/8/11 revealed that she was aware that the CD and hymn book were missing. She stated that she was present when R101's family member told two staff members E6 (CNA) and E7 (CNA) about the missing items.

A review of the facilities policy entitled, "Concern-Resident/Family" states under "Employee Responsibilities:
4. Initiate the Resident Concern Report for any and all concerns.
a. The employee who receives the complaint from the resident or family is the one responsible for completing the form in one of two ways
*The employee should assist the resident/family to complete the form.
*The employee should complete the form for the resident/family about the complaint."

The facility failed to document and report that a resident was missing a personal item when it was reported to facility staff by the resident's family.

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: December 12, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from December 1, 2011 through December 12, 2011. The deficiencies contained in this report are based on observations, interviews, review of resident's records and review of other documentation as indicated. The facility census the first day of the survey was 110. The Stage II sample totaled thirty-nine (39) residents.	Cross Reference to CMS 2567 survey report date completed December 12, 2011, F225, F246, F278, F253, F323, F371, F431, F441, F463, F467, F166 with a Plan of Correction Date of January 30, 2012.
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 12/12/11, F166, F225, F246, F253, F278, F323, F431, F441, F463 and F467.	
3201.7.5	**Kitchen and Food Storage Areas.**	

Provider's Signature Kathleen M Rucci Title Administrator Date 12/26/11

DELAWARE HEALTH AND SOCIAL SERVICES
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NAME OF FACILITY: Arbors at New Castle **DATE SURVEY COMPLETED: December 12, 2011**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Facilities shall comply with the Delaware Food Code. **This requirement was not met as evidenced by:** Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 4-501.114, 4-501.116, and 5-202.12 of the State of Delaware Food Code. Findings include: **4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness.** **(C) A quaternary ammonium compound solution shall:** **(1) Have a minimum temperature of 24°C (75°F),** **(2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling, and** **(3) Be used only in water with 500 MG/L hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions;** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 12/12/11, F371, example 2. **4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration.** **Concentration of the sanitizing solution**	

NAME OF FACILITY: Arbors at New Castle

DATE SURVEY COMPLETED: December 12, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	shall be accurately determined by using a test kit or other device. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 12/12/11, F371, example 2. **5-202.12 Handwashing Sink, Installation.** **(A) A handwashing sink shall be equipped to provide water at a temperature of at least 38°C (100°F) through a mixing valve or combination faucet.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 12/12/11, F371, example 1.	